11.c. ~~Services for individuals with~~ Speech, language, and hearing ~~and language disorders~~ therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

**Speech-language pathologist** is defined as a person who has a certificate of clinical competence in speech-language pathologies from the American Speech-Language-Hearing Association and meets the state licensure and registration requirements for the services the person provides.

Coverage of **speech-language therapy services** does *not* include:

(1) Services that are not documented in the recipient's health care record.
(2) Services by more than one provider of the same type for the same diagnosis unless the service is provided by a school district as specified in the recipient's individualized education plan.
(3) Services that are denied Medicare payment because of the provider's failure to comply with Medicare requirements.
(4) Services that are provided without written referral.
(5) Services not medically necessary.
(6) Services that are not part of the recipient's plan of care.
(7) Services provided in a nursing facility, ICF/MR or day training and habilitation services center if the cost of speech-language pathology has been included in the facility's per diem.
(8) Services provided by a speech-language pathologist other than the pathologist billing for the service, or a person completing the clinical fellowship year under the supervision of the pathologist, unless the pathologist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case, the agency, facility or physician must bill for the service.

11.c. ~~Services for individuals with~~ Speech, language, and hearing ~~and language disorders~~ therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

(9) Services provided by an independently enrolled speech language pathologist who does not maintain an office at his or her own expense.

Coverage of **hearing (audiology) therapy services** is limited to:

(1) Services provided upon written referral by a physician, physician assistant or nurse practitioner.
(2) Services provided by an independently enrolled audiologist who maintains an office at their own expense or an audiologist who is employed by and providing audiology services in a hospital, rehabilitation agency, home health agency, or clinic.
(3) Services provided to a recipient who is expected to progress toward or achieve the objective specified in their plan of care within a 60-day period.
(4) Services provided under a written treatment plan which is reviewed at least once every 60 days, with certification and recertification by the ordering physician or physician assistant. If the service is provided to a Medicare beneficiary and covered by Medicare, the physician or physician delegate must review the plan of care and visit the patient at intervals required by Medicare rather than at intervals required by MA.
(5) For long term care recipients, services for which there is a statement in the clinical record every 30 days by the audiologist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. (This statement is not required for an initial evaluation).

11.c. ~~Services for individuals with~~ Speech, language, and hearing ~~and language disorders~~ therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

(6) Services provided in the independent audiologist's own office, recipient's home, nursing facility, ICF/MR, or day training and habilitation services site.

**Audiologist** is defined as an individual who has a certificate of clinical competence from the American Speech-Language-Hearing Association.

Coverage of **hearing (audiology) therapy services** does *not* include:

(1) Services that are not documented in the recipient's clinical record, even if the services were authorized by a physician.
(2) Training or consultation provided by an audiologist to an agency, facility, or other institution.
(3) Services provided by an audiologist other than the audiologist billing for the services, or a person completing the clinical fellowship year under the supervision of the audiologist, unless the audiologist provided the services in a hospital, rehabilitation agency, home health agency, or clinic, or as an employee of a physician or long-term care facility; in which case the contracting or employing facility, agency, or person must bill for the services.

**Hearing aid services:** After a physician rules out medical and surgical contraindications, the physician refers the recipient for an audiologic evaluation. An audiologist or otolaryngologist provides audiologic testing, and if a hearing aid is indicated, prescribes a specific hearing aid offered under the hearing aid volume purchase contract or refers the recipient to a hearing aid services provider.

11.c. ~~Services for individuals with~~ Speech, language, and hearing ~~and language disorders~~ therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

Payment is made to hearing aid services providers for hearing aids, dispensing fees, hearing aid repairs, accessories, ear molds when not provided with the hearing aid and batteries.

Coverage of **hearing aids** is limited to:

(1) One monaural or one set of binaural hearing aids within a period of five years unless prior authorized. A hearing aid will not be replaced when the recipient has received a replacement hearing aid twice within the five year period previous to the date of the request.
(2) Non-contract hearing aids require prior authorization.

Coverage of **hearing aids** does *not* include:

(1) Replacement batteries provided on a scheduled basis regardless of their actual need.
(2) Services specified as part of the contract price when billed on a separate claim for payment. This includes any charges for repair of hearing aids under warranty.
(3) Routine screening of individuals or groups for identification of hearing problems.
(4) Separate reimbursement for postage, handling, taxes, mileage, or pick-up and delivery.
(5) Nonelectronic hearing aids, telephone amplifiers, vibrating molds, dry aid kits, and battery chargers.
(6) Maintenance, cleaning, and checking of hearing aids, unless there has been a request or referral for the service by the person who owns the hearing aid, the person's family, guardian or attending physician.
(7) Loaner hearing aid charges.
(8) Canal type hearing aids.
(9) A noncontract hearing aid that is obtained without prior authorization.

11.c. ~~Services for individuals with~~ Speech, language, and hearing ~~and language disorders~~ therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

(10) Services included in the dispensing fee when billed on a separate claim for payment.
(11) Hearing aid services to a resident of a long-term care facility if the services did not result from a request by the resident, a referral by a registered nurse or licensed practical nurse who is employed by the long-term care facility, or a referral by the resident's family, guardian or attending physician.
(12) Hearing aid services prescribed or ordered by a physician if the physician or entity commits a felony listed in United States Code, title 42, section 1320a-7b, subject to the "safe harbor" exceptions listed in 42 CFR 1001.952.
(13) Replacement of a lost, stolen or damaged hearing aid if MA has provided three hearing aids in the five years prior to the date of the request for a replacement.

**Augmentative and alternative communication devices** are defined as devices dedicated to transmitting or producing messages or symbols in a manner that compensates for the impairment and disability of a recipient with severe expressive communication disorders. Examples include: communication picture books, communication charts and boards, and mechanical or electronic dedicated devices. Prior authorization must be obtained for all augmentative communication devices.

Coverage of **augmentative and alternative communication devices** is limited to:

(1) Evaluation for use of augmentative and alternative communication devices to supplement oral speech.
(2) Speech pathologists may only provide modification and programming of augmentative and alternative communication devices.
(3) Construction, programming or adaptation of augmentative and alternative communication devices.

12. Prescribed drugs, dentures, and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

See Items 12.a. through 12.d.

12.a. Prescribed drugs.

**The following providers are eligible for payment for dispensing prescribed drugs:**

(1) A pharmacy that is licensed by the Minnesota Board of Pharmacy.
(2) An out of state pharmacy that complies with the licensing and certification requirements of the state in which it is located.
(3) A physician located in a local trade area where there is no Medicaid enrolled pharmacy. To be eligible for payment, the physician shall personally dispense the prescribed drug according to applicable Minnesota Statutes and shall adhere to the labeling requirements of the Minnesota Board of Pharmacy.
(4) A physician or nurse practitioner employed by or under contract with a community health board, for the purposes of communicable disease control.

**The following limitations apply to pharmacy services:**

(1) With the exception noted below, the prescribed drug must be a drug or compounded prescription that is made by a manufacturer that has a rebate with the Health Care Financing Administration (HCFA) and included in the Minnesota Department of Human Services drug formulary. The formulary is established in accordance with §1927 of the Social Security Act. See Drug Formulary.

A prescribed drug is covered if it has Investigational New Drug (IND) status with an IND number by the United States Food and Drug Administration (FDA), even though the manufacturer does not have a rebate with HCFA. When the prescribed drug receives FDA approval, the manufacturer must have a rebate agreement for the drug in order for the drug to be covered.

(2) A prescribed drug must be dispensed in the quantity specified on the prescription unless the pharmacy is using unit dose dispensing or the specified quantity is not available in the pharmacy when the prescription is dispensed. Only one dispensing fee is allowed for dispensing the quantity specified on the prescription.

12.a. Prescribed drugs. (continued)

(3) The dispensed quantity of a prescribed drug must not exceed a three-month supply.

(4) An initial or refill prescription for a maintenance drug shall be dispensed in not less than a 30-day supply unless the pharmacy is using unit dose dispensing. No additional dispensing fee shall be paid until that quantity is used by the recipient.

(5) Except as provided in item (6), coverage of the dispensing fee for a particular pharmacy or dispensing physician for a maintenance drug for a recipient is limited to one fee per 30-day supply.

(6) More than one dispensing fee per calendar month for a maintenance drug for a recipient is allowed if:

(a) the record kept by the pharmacist or dispensing physician documents that there is a significant chance of overdosage by the recipient if a larger quantity of drug is dispensed, and if the pharmacist or dispensing physician writes a statement of this reason on the prescription; or

(b) the drug is clozapine.

(7) A refill of a prescription must be authorized by the practitioner. Refilled prescriptions must be documented in the prescription file, initialed by the pharmacist who refills the prescription, and approved by the practitioner as consistent with accepted pharmacy practice under Minnesota Statutes.

(8) Unless the practitioner has written in his or her own handwriting "Dispense as Written-Brand Necessary" or "DAW-Brand Necessary" on the prescription, generic drugs must be dispensed to recipients if:

(a) the generically equivalent drug is approved and is determined as therapeutically equivalent by the FDA; and

12.a. Prescribed drugs. (continued)

(b) the charge for the substituted generically equivalent drug does not exceed the charge for the drug originally prescribed.

(9) Over the counter medications must be dispensed in the manufacturer's unopened package, except that Sorbitol may be repackaged.

(10) The following limits apply to drugs dispensed under unit dose packaging:

(a) Dispensing fees for drugs dispensed in unit dose packaging shall not be paid more often than once per calendar month or when a minimum of 30 dosage units have been dispensed, whichever results in the lesser number of dispensing fees.

(b) Only one dispensing fee per calendar month will be paid for each maintenance drug, regardless of the type of unit dose system used or the number of times during the month the pharmacist dispenses the drug.

(c) An additional dispensing fee per prescription shall be paid to pharmacists using an in-pharmacy packaged unit dose system (except for over-the-counter [OTC] medications) approved by the Board of Pharmacy for the return of drugs when dispensing to recipients in a long-term care facility if:

(i) the pharmacy is registered with the Department by filing an addendum to the provider agreement;

(ii) a minimum 30-day supply of the drug is dispensed, although a lesser quantity may be dispensed for an acute course of medication therapy for a specified time period;

12.a. Prescribed drugs. (continued)

(iii) the national drug code from the drug stock container used to fill the unit dose package is identified to the Department;

(iv) the unit dose package containing the drug meets the packaging standards set forth in Minnesota Statutes that govern the return of unused drugs to the pharmacy for reuse and documentation that unit dose packaging meets permeability standards of the Board of Pharmacy; and

(v) the pharmacy provider credits the Department for the actual acquisition cost of all unused drugs that are eligible for return and reuse.

(11) Delivery charges for a drug are not covered.

**Drug Formulary:**

All drugs and compounded prescriptions made by a manufacturer that are subject to a rebate agreement with HCFA are included in the drug formulary, with the following two limitations to coverage:

(1) The following drugs require prior authorization:
- (a) Alglucerase (Ceredase)
- (b) Agents used to promote smoking cessation (includes patches, nasal sprays, gum, inhalers)
- (c) Botulinum Toxin Type A (Botox)
- (d) Demeclocycline (Declomycin)
- (e) Epoetin Alfa/Erythropoietion/EPO (Epogen and Procrit)
- (f) Filgrastim/G-CSF (Neupogen)
- (g) Granisetron (Kytril): for > 4 consecutive weeks continuous treatment
- (h) Interferon Alfa-n3 (Alferon N)
- (i) Interferon Gamma-1b (Actimmune)
- (j) Lansoprazole (Prevacid): for > 8 consecutive weeks continuous treatment
- (k) Omeprazole (Prilosec): for > 8 consecutive weeks continuous treatment
- (l) Ondansetron (Zofran): for > 4 consecutive weeks continuous treatment
- (m) Sargramostim/GM-CSF (Leukine and Prokine)
- (n) Viagra (Sildenafil)